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Therapeutic Abortion without Inpatient Hospitalization

An Early Experience with 325 Cases

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■ *Analysis of 325 first trimester abortions performed on women who spent an average of less than six hours on the hospital premises, indicates that management without inpatient hospitalization is acceptable as an interim measure pending the development of alternative methods of dealing with the anticipated large number of therapeutic abortions.*

SINCE THE LIBERALIZATION of the California abortion law in 1967, requests for therapeutic abortion have increased at an astounding rate. Experience in states which liberalized their abortion laws since 1967 has been similar. In California the number of abortions has essentially doubled during each six months since the change of law, so that rates in several major hospitals have now reached 500 to 700 abortions per 1,000 births, while in at least one hospital abortions exceed births. With some 15,000 therapeutic abortions performed in 1969, it is likely that 50,000 to 100,000 abortions will have been performed in California hospitals during 1970. Indeed, this state's Department of Health projects, on a statistical basis, that the number of requests for the procedure will continue to rise, with no plateau anticipated in the near future.

The increase in demand for abortion has usurped hospital beds, pre-empted the time of physicians, nurses and admissions personnel, and overcrowded surgical schedules, thus diminishing the time available for other elective procedures. Foreseeing no immediate relief of this acute situation, in May 1970 the Kaiser Foundation medical staff in San Francisco altered its policy to permit performance of first trimester therapeutic abortions without hospitalization. The results of our first eight months' experience are reported here.

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Patients and Methods

During the eight-month period May through December 1970, 353 first trimester therapeutic abortions were performed by suction curettage as outpatient procedures. The charts for 325 patients were available for review. Of this group, 149 (46 percent) were married, 158 (49 percent) were single, and 18 (5 percent) were divorced or separated. There were 234 (72 percent) white, 68 (21 percent) black and 23 (7 percent) oriental.

The age range was 14 to 35 years, with 116 teenagers and 98 women older than 30. One hundred and forty-eight (46 percent) of the women were pregnant for the first time; 47 had been pregnant at least four times previously.

Uterine size conformed to six weeks' gestation or less in 39 patients (12 percent), to eight weeks' gestation in 94 (29 percent), to ten weeks in 123 (39 percent), and at least 12 weeks in 68 (21 percent). In two cases the uterus was described as being 14 weeks', and in one as being 15 weeks' size. The uterine size at the time of curettage correlated well with assumed gestational age in 85 percent of the patients. There was a discrepancy of more than 4 weeks' gestational size in 26 patients, 14 of whose uteri were smaller than expected. Five patients were found not to be pregnant; four showed positive response to pregnancy test before curettage, while a pregnancy test was not ordered in one patient in whom a clinical diagnosis of pregnancy was based upon an enlarged uterus. In two the uterine size and secretory endometrium were normal for the nongravid state; in the other three patients, proliferative endometrium was found in normal sized uteri.

Following the necessary therapeutic abortion adjudication procedure, and in accordance with the statutory requirements of the State of California, each patient was instructed to appear in the hospital's emergency room at a scheduled time on the day before the operation, for a medical history, physical examination and laboratory evaluation. Immune globulin Rh_0 was prepared when indicated, to be given immediately after abortion. The patients were ordered to take nothing by mouth after midnight, and to appear at the admission office approximately one hour before the procedure. Patients were escorted to the surgery suite, where pre-anesthetic medication was administered. All but two were given general anesthesia with pentothal, succinylcholine and nitrous oxide. Thirty-one patients also received methoxyflurane. One, with acute thyrotoxicosis, was given spinal anesthesia, and one patient with chronic anemia received a paracervical block. A standard vacuum aspiration apparatus* was used, followed by gentle, sharp curettage. Intravenously administered oxytocin and intramuscularly injected methylergonovine maleate were routinely used during the procedure. The patients were observed in the recovery room until fully ambulatory, then discharged home, accompanied by a relative or friend.

Results

The mean time spent on the hospital premises for the 325 patients was 5.25 hours (range: 3.5 to 8 hours). The duration of anesthesia was less than 30 minutes in 299 (92 percent) patients. The operative procedure required less than 20 minutes in 302 (93 percent) (range: 3 to 36 minutes). The estimated blood loss was less than 50 ml in 123 (38 percent) patients, 50 to 100 ml in 88 (27 percent), 100 to 150 ml in 75 (23 percent), and more than 150 ml in 39 (12 percent) patients. Two patients lost 300 ml, one lost 600 ml and one lost 1000 ml of blood. No blood replacement was required. The mean time spent in the recovery room until discharge was 3.25 hours (range: 1.5 to 5.75 hours).

Immediate postoperative complications included nausea and vomiting of a clear or yellow mucoid material by 41 patients, and moderate to heavy uterine bleeding in nine. It was necessary to admit two patients to the hospital overnight for observation because of copious bleeding. A uterine perforation occurred with a sharp curette in one patient subsequently found not to be pregnant. She remained asymptomatic and was discharged after 24 hours of observation. One patient experienced sharp pelvic pain for three hours, after which it abated. One patient aspirated vomitus during the procedure. She was treated for aspiration pneumonitis with tetracycline and steroids, and was discharged on the fourth postoperative day. Twelve of the 325 patients had delayed postabortal complications: endometritis (five cases), retained products of conception (five), subinvolution (one), and cystitis one). Curettage was repeated in all of the patients with retained products of conception.

*Berkeley Tonometer Company, Berkeley.

Two hundred and forty-eight (76 percent) patients were seen in the clinic within four weeks after abortion. All were offered some form of contraceptive. It is of interest that nine of the women frankly refused all types of contraceptive advice.

Comment

As therapeutic abortion becomes legally available throughout the nation, either by national judicial or state legislative decision, many hospitals will be confronted with an awesome increase in the number of requests for the procedure. We feel that therapeutic abortion without inpatient hospitalization is safe and efficient; and it has met with favorable patient comment.

Patient cooperation in following instructions, including preoperative restriction of oral intake, has been excellent. The addition of hydroxyzine hydrochloride (50 mg) to the preoperatively administered meperidine (50 mg) and atropine (0.4 mg), given intramuscularly, has eliminated postoperative nausea and vomiting. The use of methoxyflurane did not appear to alter blood loss or postoperative recovery time; however, the number of cases is insufficient to permit statistically significant comparison.

We have found that grasping the anterior lip of the cervix with a DeLee forceps and placing a single-tooth tenaculum through the fenestration of the forceps affords excellent hold with minimal risk of tearing. A trial of a cervical Vibrodilator* did not facilitate cervical dilatation or shorten operating time, and its use was discontinued. The largest size Hegar dilator and aspiration tip used were found to generally correspond to the number of weeks of gestation —for example, a No. 12 Hegar dilator and an 11 to 12 mm aspiration tip would be used on a 12 weeks' sized uterus.

We agree with Margolis and Overstreet[1] that since abortion complications, if they occur, arise more than 48 hours post-abortion, the conventional 24 to 48-hour hospital stay serves no real purpose in preventing or discovering such complications. Therapeutic abortion without inpatient hospitalization has proved to be an acceptable, temporary means of accommodating the rapidly increasing number of abortion requests. It is anticipated that this system of legal abortion will ultimately prove inadequate and that more efficient alternatives, such as abortion clinics, will have to be developed.

*Berkeley Tonometer Company, Berkeley.

REFERENCE

1. Margolis AJ, Overstreet EW: Legal abortion without hospitalization (Editorial). Obstet Gynecol 36:479, 1970

MALE CLIMACTERIC

Once regarded as a myth, the male climacteric is now seen as a real, though rare, event. The true male climacteric is associated with failure of testicular function. A decline in androgens is measured by urinary secretion with a rise in pituitary gonadotropins. The symptoms are listlessness, loss of libido, and difficulty in concentration and recall. Occasionally there is a vasomotor crisis. If this occurs, it's almost pathognomonic. But most changes in the male at middle age are not on the basis of climacteric, but rather on the basis of psychological attitudes with symptoms expressed being manifestations of depression and anxiety. If one is not certain about the differential diagnosis between the true climacteric and the depressed middle-aged male, testosterone propionate, either intramuscularly five times a week for two weeks or in sublingual form, will result in rather rapid improvement in the individual undergoing the climacteric.

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